PROVIDER′S PETITION FOR PAYMENT OF MEDICAL AND RELATED SERVICES

STATE OF MAINE
WORKERS′ COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

HEALTH CARE PROVIDER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE NAME: _____

EMPLOYEE SOCIAL SECURITY NUMBER: XXX-XX-_____

DATE OF INJURY: _____

BOARD FILE NUMBER: _____
(IF KNOWN)

EMPLOYER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

1. On _____, _____
MONTH DAY Y EAR EMPLOYEE NAME

experienced a work-related injury while working for _____.
EMPLOYER NAME

2. The charges for medical and related services in connection with this injury amount to: $_____.
ATTACH COPIES OF ALL BILLS

WHEREFORE, the health care provider asks the Board to order payment of the attached work-related medical bills and services pursuant to 39-A M.R.S.A.

_____
SIGNATURE OF HEALTH CARE REPRESENTATIVE

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

_____
NAME OF PROVIDER'S ATTORNEY (IF ANY)

_____
STREET/P.O. BOX

_____
CITY, STATE, ZIP